EVIDENCE BRIEF
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THE IMPACT OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT INTERVENTIONS ON PEOPLE AFFECTED BY HUMANITARIAN EMERGENCIES

About this evidence brief

This brief provides an overview of *The impact of mental health and psychosocial support interventions on people affected by humanitarian emergencies* – a systematic review published in March 2017 by the Humanitarian Evidence Programme and carried out by a team from the EPPI-Centre, University College London. It summarizes key findings in response to four research questions, indicates the country contexts from which evidence is drawn, outlines the methodology, highlights research gaps and provides references to the original literature.

The brief aims to assist policymakers, practitioners and researchers in assessing the available evidence in this field. It does not provide advice on which interventions or approaches are more or less appropriate in any given context. The varied and varying nature of crisis, vulnerability, goals of humanitarian programming, local conditions and quality of available data make the evidence highly contextual.
The views and opinions expressed herein are those of the authors and do not necessarily represent those of Oxfam, Feinstein or the UK government.

Objectives of the systematic review

This systematic review draws together primary research on mental health and psychosocial support (MHPSS) programmes for people affected by humanitarian crises in low- and middle-income countries (LMICs). It investigates both the process of implementing MHPSS programmes and their receipt by affected populations, as well as assessing their intended and unintended effects. Specifically, it sets out to respond to the following research questions:

- Q1: What are the barriers to, and facilitators of, implementing and receiving MHPSS interventions delivered to populations affected by humanitarian emergencies?
- Q2: What are the effects of MHPSS interventions delivered to populations affected by humanitarian emergencies?
- Q3: What are the key features of effective MHPSS interventions and how can they be successfully developed and implemented?
- Q4: What are the gaps in research evidence for supporting delivery and achieving the intended outcomes of MHPSS interventions?

About the systematic review

The protocol, full review and executive summary on which this evidence brief is based are available from Feinstein International Center, Oxfam Policy & Practice and UK government websites. Citation:

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About the Humanitarian Evidence Programme

The Humanitarian Evidence Programme is a partnership between Oxfam GB and the Feinstein International Center at the Friedman School of Nutrition Science and Policy, Tufts University. It is funded by the United Kingdom (UK) government's Department for International Development (DFID) through the Humanitarian Innovation and Evidence Programme.

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Findings

Figure 1: Summary of key findings in response to Q1 – barriers and facilitators of MHPSS interventions. Source: The research team

Q1: Themes		No. of studies	Quality	
			Reliability[1]	Usefulness[2]
Engagement with local communities and government agencies	Enable community mobilization and sensitization	n=3	1 high 1 medium 1 low	2 high 1 medium
	Develop effective local community and government partnerships	n=2	1 high 1 medium	1 high 1 medium
	Establish good relationships with parents to support uptake of MHPSS programmes	n=4	1 high 2 low	2 medium 1 low
Sufficient number of trained MHPSS programme providers	Address challenge of recruiting and retaining providers	n=3	1 high 2 low	2 medium 1 low
	Ensure providers are trained to deliver MHPSS programmes	n=4	1 high 3 low	3 medium 1 low
Experience of programme activities	Increase meaningful and enjoyable engagement of programme activities	n=3	2 high 1 medium	2 high 1 medium
	Ensure cultural relevance of activities	n=2	2 medium	2 high
Benefits of group-based programmes	Provide a group-based resource and source of support	n=4	2 high 2 medium	3 high 1 medium
	Provide a safe space to tell stories	n=2	2 medium	2 high
Quality and nature of relationships with programme providers	Build trusting and supportive relationships	n=2	2 medium	2 high
	Develop personal qualities so providers can act as role models	n=3	3 medium	3 high

Notes: 1. Reliability was judged according to whether steps had been taken to increase rigour in methods of sampling and data collection/analysis and the extent to which the study findings were grounded in the data. 2. Usefulness was judged based on whether the study privileged the perspectives of participants and provided a breadth and depth of findings in response to the review question.

Q1: What are the barriers to, and facilitators of, implementing and receiving MHPSS interventions delivered to populations affected by humanitarian emergencies?

The key findings in response to this question are summarized in Figure 1.

- Of the 82 studies included in this review, 13 evaluated the process of implementation or receipt of MHPSS programmes:
  - of these, 10 were judged to be of either high or medium reliability or usefulness, providing an overall sound evidence base
  - three studies were of low reliability, two provided medium useful findings, and one was low on both criteria.
- **Community engagement** was a key mechanism to support the successful implementation and uptake of MHPSS programmes in humanitarian settings:
  - mental health sensitization, mobilization strategies and the need to develop effective partnerships with local communities, government and non-governmental organizations (NGOs) were seen as pivotal in increasing programme accessibility and reach
  - establishing good relationships with parents may also be important when there is a need to communicate the value of children and young people (CYP) participating in MHPSS programmes.
- **Sufficient numbers of trained MHPSS providers** were essential in ensuring that a range of MHPSS programmes were delivered as planned; however, this could be challenging in resource-limited settings where there can be a lack of incentives to work in the mental health sector.
- Recipient perspectives suggest that **MHPSS programmes need to be socially and culturally meaningful to local populations** to ensure that they are appealing and to enhance their ability to achieve their intended aims.
- **Benefits of group-based programmes** included providing an opportunity to connect with people from similar circumstances and backgrounds and to share stories, helping to promote greater social cohesion and reducing social isolation.
- **Building trusting and supporting relationships** was important to recipients and helped to maximize their engagement and increase the impact of programmes. Providers who could relate by bridging differences, being nurturing and acting as role models were highly valued.

Definitions

In this review MHPSS are broadly defined as interventions 'to protect or promote psychosocial well-being and/or prevent or treat mental disorder' (Inter-Agency Standing Committee (IASC), 2007: 11).

Figure 2: Summary of key findings in response to Q2 – MHPSS interventions for CYP. Source: The research team

Impact of MHPSS	Pooled effect size; or stated otherwise	Size and quality of evidence and consistency (n = number of participants)	Overall strength of evidence
1. Impact of all MHPSS programmes			
1. Post-traumatic stress disorder (PTSD)	-0.46 (-0.69, -0.24)	21 studies; n=3,615; 16 high- or medium-quality studies; inconsistent	**Moderate**
2. Depression	-0.06 (-0.27, 0.14)	14 studies; n=3,516; 10 high- or medium-quality studies; inconsistent	**Moderate**
3. Conduct problems	-0.45 (-0.81, -0.09)	8 studies; n=1,918; 7 high- or medium-quality studies; inconsistent	**Moderate**
4. Functional impairment	-0.24 (-0.39, -0.09)	8 studies; n=1,574; 7 high- or medium-quality studies; consistent	**Strong**
5. Prosocial behaviours	0.09 (-0.16, 0.34)	8 studies; n=1,997; 7 high- or medium-quality studies; inconsistent	**Moderate**
6. Psychological distress	-0.24 (-0.52, 0.03)	8 studies; n=1,908; 6 high- or medium-quality studies; inconsistent	**Moderate**
7. Anxiety	0.02 (-0.11, 0.14)	6 studies; n=1,886; 5 high- or medium-quality studies; consistent	**Strong**
8. Emotional problems	-1.02 (-1.5, -0.53)	5 studies; n=955; 4 high- or medium-quality studies; inconsistent	**Limited**
9. Hope	0.45 (0.19, 0.71)	5 studies; n=1,703; 3 high- or medium-quality studies; inconsistent	**Limited**
10. Social support	-0.41 (-0.88, 0.07)	2 studies n=416; 2 high- or medium-quality studies; inconsistent	**Limited**
11. Somatic complaints	-0.36 (-1.27, 0.55)	2 studies; n=197; 1 high-quality study	**Limited**
Coping, grief, suicide, guilt, stigmatization, resilience	**Insufficient**		
2. Impact of cognitive behavioural therapy (CBT)			
2.1 Impact of trauma-focused CBT (TF-CBT)			
1. PTSD	-2.21 (-2.7, -1.72)	3 studies; n=152; 3 high- or medium-quality studies; consistent	**Moderate**
2. Conduct problems	-1.2 (-1.58, -0.81)	3 studies; n=152; 3 high- or medium-quality studies; consistent	**Moderate**
3. Prosocial behaviours	0.63 (-0.55, 1.82)	3 studies; n=152; 3 high- or medium-quality studies; inconsistent	**Limited**
4. Emotional problems	-1.76 (-2.3, -1.22)	3 studies; n=152; 3 high- or medium-quality studies; consistent	**Moderate**
Psychological distress	**Insufficient**		
2.2 Impact of classroom/school-based intervention CBT (CBI-CBT)			
1. PTSD	-0.198 (-0.50, 0.11)	6 studies; n=2,102; 4 high- or medium-quality studies; inconsistent	**Limited**
2. Depression	-0.26 (-0.45, -0.07)	6 studies; n=2,102; 4 high- or medium-quality studies; inconsistent	**Limited**
3. Functional impairment	-0.27 (-0.47, -0.08)	5 studies; n=1,458; 4 medium-quality studies; inconsistent	**Limited**
4. Hope	0.45 (0.19, 0.71)	5 studies; n=1,703; 3 medium-quality studies; inconsistent	**Limited**
5. Conduct problems	-0.17 (-0.61, 0.28)	4 studies; n=1,607; 3 medium-quality studies; inconsistent	**Limited**
6. Anxiety	-0.04 (-0.15, 0.07)	4 studies; n=1,607; 3 medium-quality studies; consistent	**Moderate**
7. Prosocial behaviours	0.08 (-0.16, 0.31)	3 studies; n=1,204; 2 medium-quality studies; inconsistent	**Limited**
8. Psychological distress	-0.24 (-0.51, 0.04)	3 studies; n=1,204; 2 medium-quality studies; inconsistent	**Limited**

Impact of MHPSS	Pooled effect size; or stated otherwise	Size and quality of evidence and consistency (n = number of participants)	Overall strength of evidence
Coping, social support, somatic complaints, emotional problems	Insufficient		
2.3 Impact of Teaching Recovery Techniques CBT (TRT-CBT)			
1. PTSD	-0.35 (-0.74, 0.04)	3 studies; n=558; 2 high- or medium-quality studies; consistent	**Moderate**
Depression, psychological distress, prosocial behaviours, resilience	Insufficient		
3. Impact of Narrative Exposure Therapy (NET)			
1. PTSD	-0.11 (-0.37, 0.15)	4 studies; n=287; 4 high- or medium-quality studies; consistent	**Moderate**
2. Depression	0.66 (-0.54, 1.86)	2 studies; n=209; 2 high- or medium-quality studies; inconsistent	**Limited**
3. Functional impairment	-0.52 (-1.02, -0.03)	2 studies; n=116; 2 high- or medium-quality studies; consistent	**Moderate**
4. Anxiety	Not pooled effect size: 0.20 (-0.15, 0.56)	1 study; n=124; 1 high-quality study	**Limited**
5. Somatic complaints	Not pooled effect size: 0.16 (-0.55, 0.87)	1 study; n=31; 1 high-quality study	**Limited**
6. School performance	No impact on school grade (p<0.19)	1 study; n=47; 1 high-quality study	**Limited**
Grief, guilt, suicide, stigmatization	Insufficient		
4. Impact of psychosocial interventions			
1. PTSD	-0.67 (-1.39, 0.04)	4 studies; n=381; 4 high- and medium-quality studies; Inconsistent	**Limited**
2. Depression	0.27 (0.07, 0.46)	4 studies; n=631; 4 high- and medium-quality studies; consistent	**Moderate**
3. Emotional problems	-0.98 (-2.82, 0.86)	2 studies; n=209; 2 high-quality studies; inconsistent	**Limited**
4. Conduct problems	-0.45 (-1.76, 0.86)	2 studies; n=209; 2 high-quality studies; inconsistent	**Limited**
5. Functional impairment	-0.01 (-0.31, 0.29)	2 studies; n=399; 2 medium-quality studies; consistent	**Moderate**
6. Prosocial behaviours	-0.27 (-0.55, 0.02)	2 studies; n=209; 2 low risk of bias studies; consistent	**Moderate**
7. Anxiety	Trend in favour of the control group	1 study; n=145; 1 high-quality study	**Limited**
8. Psychological distress	No impact	1 study; n=87; 1 high-quality study	**Limited**
9. Physical health	Mixed	2 studies; n=232; 2 high-quality studies	**Limited**
10. Social support	Positive trend in favour of the intervention group compared with the control group	1 study; n=87; 1 high-quality study	**Limited**
Suicide, guilt and stigmatization	Insufficient		

Q2: What are the effects of MHPSS interventions delivered to populations affected by humanitarian emergencies?

MHPSS interventions delivered to children

The key findings in response to this question are summarized in Figure 2.

- Of the 82 studies included in this review, 26 randomized controlled trials (RCTs) evaluated the effects of MHPSS interventions delivered to children:
  - eight of the RCT studies were judged to be low risk of bias, 13 to be medium risk of bias and five high risk of bias
  - trial evaluations for CYP were likely to use cognitive behavioural techniques or to employ other psychotherapy modalities such as narrative exposure or interpersonal grief-focused therapy. Interventions were delivered primarily in whole-classroom or other school-based settings, for a maximum duration of three months.

- There is **strong evidence** that MHPSS programmes are effective in reducing functional impairment but have little or no impact on anxiety.
- There is moderate evidence that:
  - MHPSS programmes probably slightly reduce symptoms of post-traumatic stress disorder (PTSD), psychological distress and conduct problems
  - MHPSS programmes may have no impact on depression or prosocial behaviours
  - trauma-focused cognitive behavioural therapy (TF-CBT) programmes are effective in reducing PTSD symptoms, conduct problems and emotional problems
  - classroom/school-based intervention (CBI-CBT) programmes may have little or no impact on anxiety
  - Narrative Exposure Therapy (NET) can improve symptoms of functional impairment
  - NET probably has little impact on PTSD symptoms
  - psychosocial interventions may lead to an increased level of depression symptoms and may slightly decrease prosocial behaviours
  - psychosocial interventions probably make no improvement to functional impairment.
- There is limited evidence that:
  - MHPSS programmes may reduce emotional problems, slightly reduce somatic complaints and marginally increase hope
  - MHPSS programmes may slightly decrease social support perceived by CYP
  - TF-CBT programmes may improve prosocial behaviours
  - CBI-CBT programmes appear to be effective in reducing depression, functional impairment and psychological distress and in slightly improving hope, but might have little or no impact on PTSD symptoms, conduct problems or prosocial behaviours
  - NET may have a negative impact on depression, or may slightly increase anxiety and somatic complaints, and probably has little impact on school performance
  - psychosocial interventions may reduce PTSD symptoms, emotional problems and conduct problems.
- **Narrative synthesis** suggests that:
  - CBT may have no impact on social support (two medium risk of bias studies)
  - NET (one low risk of bias study) may have a negative trend on anxiety and somatic complaints, and no impact on school performance
  - psychotherapy programmes show a positive trend (from four studies, one medium and three high risk of bias: mind and body skills group, counselling and a school-based trauma-grief intervention) in reducing PTSD symptoms
  - psychosocial interventions may improve social support (low risk of bias study) and have no impact on psychological distress (low risk of bias study)
  - psychosocial interventions may increase anxiety symptoms (low risk of bias study)
  - psychosocial interventions may have no impact on psychosocial distress (one low risk of bias study).
- There is evidence to suggest that programme intensity is associated with the effect of MHPSS programmes for CYP on PTSD. Also, there is evidence that the follow-up period is associated with the effect of MHPSS programmes on depression for CYP.
- The review team observed no clear pattern from a small number of studies to confirm that characteristics of participants, exposure to traumatic events or family and social supports are factors influencing the impact of MHPSS programmes on CYP.

MHPSS interventions delivered to adults

The key findings in response to this question are further summarized in Figure 3.

- Of the 82 studies included in this review, findings from 20 RCTs were used in the quantitative analysis and response to this question:
  - of these, eight were judged to be low risk of bias, two medium and 10 high risk
  - studies evaluating MHPSS programmes for adults using randomized controlled methods were most likely to involve brief, focused psychotherapies delivered in 1:1 sessions in both clinical and non-clinical settings, for a maximum period of three months.
- There is moderate evidence that:
  - MHPSS programmes probably reduce PTSD, depression, anger and self-reported sexual violence
  - MHPSS programmes may have no impact on social support
  - NET is effective in reducing depression and anxiety symptoms
  - NET may have little or no impact on social support.
- There is limited evidence that:
  - MHPSS programmes may lead to improvements in symptoms of anxiety, common mental health problems and fear/avoidance – they may also slightly reduce grief and emotional problems
  - CBT is effective in reducing PTSD and depression, and may slightly reduce grief
  - NET may also reduce PTSD and common mental health problems, and may slightly improve coping
  - NET may slightly increase emotional problems.

- Narrative synthesis suggests:
  - a positive trend in favour of other psychotherapy interventions in reducing PTSD symptoms (eye movement desensitization and reprocessing (EMDR) and interpersonal psychotherapy (IPT)); depression (EMDR, counselling, IPT, Thought Field Therapy (TFT)); anger (TFT and IPT); anxiety symptoms (TFT and IPT); fear and avoidance (TFT); partner violence (IPT); and common mental health problems (counselling).

Figure 3: Summary of key findings in response to Q2 – MHPSS interventions for adults. Source: The research team

Impact of MHPSS	Pooled effect size; (95% CI); or stated otherwise	Size and quality of evidence and consistency (n = number of participants)	Overall strength of evidence
1. Impact of all MHPSS programmes			
1. PTSD	-0.75 (-0.997, -0.5)	7 studies; n=1,924; 8 medium- or high-quality studies; inconsistent	**Moderate**
2. Depression	-1.18 (-1.65, -0.71)	12 studies; n=841; 6 medium- or high-quality studies; inconsistent	**Moderate**
3. Anxiety	-1.41 (-2.21, -0.61)	6 studies; n=630; 3 high-quality studies; inconsistent	**Limited**
5. Emotional problems	-0.25 (-0.796, 0.29)	5 studies; n=653; 3 high-quality studies; inconsistent	**Limited**
6. Common mental health problems	-0.88 (-1.45, -0.30)	5 studies; n=420; 3 high-quality studies; inconsistent	**Limited**
7. Fear and avoidance	-0.73 (-1.01, -0.45)	4 studies n=254; 1 high-quality study	**Limited**
8. Anger	-0.80 (-1.13, -0.47)	3 studies; n=197; 2 medium-quality studies; consistent	**Moderate**
9. Social support	0.08 (-0.49, 0.64)	2 studies; n=52; 2 high-quality studies; consistent	**Moderate**
10. Partner violence	0.44 (-0.97, 0.09)	2 studies; n=71; 2 medium-quality studies; consistent	**Moderate**
11. Grief	-0.23 (-0.63, 0.16)	2 studies; n=147; 1 high-quality study	**Limited**
Functional impairment, conduct problems and somatic complaints	**Insufficient**		
2. Impact of CBT			
1. PTSD	-0.74 (-1.04, -0.43)	6 studies; n=989; 1 high-quality study; inconsistent	**Limited**
2. Depression	-0.54 (-1.07, -0.01)	4 studies; n=465; 1 high-quality study; inconsistent	**Limited**
3. Grief	-0.23 (-0.63, 0.16);	2 studies; n=147; 1 high-quality study; consistent	**Limited**
Functional impairment, fear and avoidance, emotional problems, anxiety, conduct problems, common mental health problems	**Insufficient**		
3. Impact of NET			
1. PTSD	-1.24 (-1.99, -0.489)	7 studies; n=596; 4 high-quality studies; inconsistent	**Limited**
2. Depression	-1.19 (-1.72, -0.66)	3 studies; n=70; 2 high-quality studies; consistent	**Moderate**
3. Common mental health problems	-1.27 (-2.31, -0.23)	4 studies; n=301; 3 high-quality studies; inconsistent	**Moderate**
4. Anxiety	-1.31 (-1.94, -0.68)	2 studies; n=52; two high-quality studies; consistent	**Moderate**
5. Social support	0.08 (-0.49, 0.64)	2 studies; n=52; two high-quality studies; consistent	**Moderate**
6. Coping	0.31 (-0.53, 1.16)	1 study; n=22; 1 high-quality study	**Limited**
7. Emotional problems	0.48 (-0.32, 1.28)	1 study; n=4; 1 high-quality study	**Limited**
Somatic complaints	**Insufficient**		

Q3: What are the key features of effective MHPSS interventions and how can they be successfully developed and implemented?

Following meta-regression analysis based on Q1 and Q2 hypotheses, and an exploration of the gaps, the review team found that programmes may be more effective if they address the following.

- Steps are taken to engage with the community and/or family members
  - 16 MHPSS programmes within the included study set (13 for CYP and three for adults) included community engagement as part of programme delivery
  - the review team's meta-regression analysis found no significant association for PTSD or depression for either population group.
- Programmes are delivered in partnership with governments and/or local agencies
  - nine RCTs cited brief examples of informal government involvement (four for CYP programmes and five for adults)
  - no significant association for PTSD or depression was found.
- The challenge of recruiting and retaining **trained providers** is overcome
  - MHPSS programmes were delivered by trained providers in 26 cases for children and 19 for adults
  - no significant association in reducing PTSD or depression was found for adults; however, a significant association was found between having trained providers and the effect of PTSD in programmes for CYP
  - further explorative examination of statistically successful MHPSS programmes in reducing PTSD in CYP supported this association, revealing that (with the exception of one) all MHPSS programmes effective in reducing PTSD were delivered by trained providers
  - all successful MHPSS programmes that reported a significant impact of MHPSS in reducing depression were delivered by trained providers.
- **Programme activities are socially and/or culturally meaningful**
  - 17 MHPSS programmes for CYP and 11 for adults aimed to be socially and culturally meaningful
  - the review team found a significant association with this aspect of programming for MHPSS programmes for CYP in depression only (p=0.031)
  - this finding was supported by explorative analysis of successful MHPSS programmes for CYP, finding that all MHPSS programmes that reported a significant impact in reducing depression were adapted to be sensitive to local cultures and social contexts
  - two studies that did not clearly report if MHPSS programmes for children had been adapted to local contexts showed a significant unintended effect of MHPSS on depression
  - no further statistical associations were found for PTSD in CYP or for either outcome in adults.
- Opportunities are provided for people to interact as a group
  - 26 programmes delivered to CYP were group-based, while only three programmes were delivered in a group format to adults
  - despite positive appraisal of the group experience in process evaluations, no significant association for PTSD or depression was found.
- Programme providers build trusting and supportive relationships with programme recipients
  - this was raised in 11 programmes for CYP and two for adults
  - for adults, no significant association was found for PTSD or depression
  - for children, a significant association was found for PTSD (p=0.003), but not for depression
  - exploration of MHPSS programmes successful in reducing PTSD and depression in CYP also revealed a non-statistical negative trend across four studies that did not emphasize the importance of establishing relationships between programmes providers and recipients.

Q4: What are the gaps in research evidence for supporting delivery and achieving the intended outcomes of MHPSS interventions?

Overall, there is a rapidly growing evidence base evaluating a broad range of MHPSS programmes for children and adults in LMICs. However, there are some notable gaps.

- Much research on MHPSS interventions focuses on post-conflict settings, with far fewer studies conducted in the context of natural disasters.
- There is a lack of studies evaluating the impact of MHPSS programmes designed to provide basic services and security.
- There is a gap in research on cost-effectiveness and long-term follow-up studies exploring the possibilities and implications of implementing MHPSS programmes in resource-constrained settings. Although RCTs provided some evidence on characteristics of participants that might moderate programme effects, similar insights from people's views were lacking in process evaluations.
- There is a lack of evidence on children under 10 years of age and adults over 55 years of

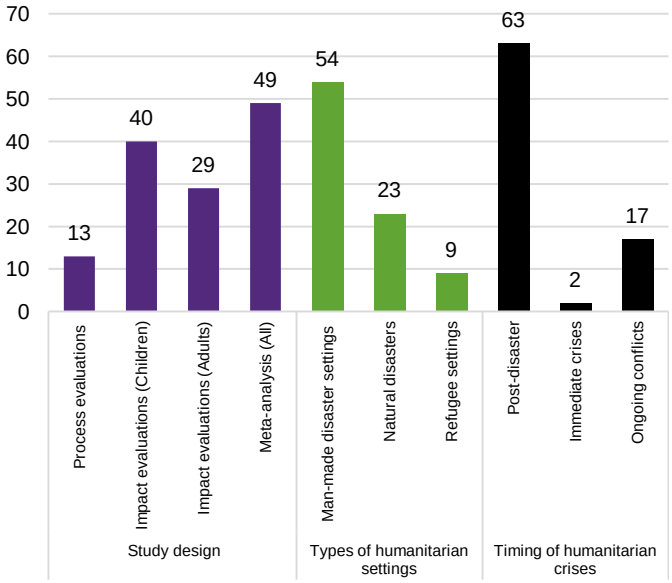
age – a common finding across social evaluations.

- Despite the relatively high volume of RCTs, there was limited crossover with process evaluations. The research team did not identify any mixed-methods evaluations and very few process evaluations investigating similar types of MHPSS programmes.

Methodology

- This review adheres to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidance. Where necessary, it has been adapted to accommodate the mixed-methods approach taken in this review.
- A scoping exercise was carried out between October and November 2015 with the aim of identifying existing systematic reviews and reviews in the field of MHPSS in humanitarian emergencies, as part of the protocol development (Bangpan et al., 2016). This led to the decision to focus on MHPSS interventions delivered in LMICs while, unlike previous reviews, retaining a broad focus on the types of MHPSS interventions and populations to synthesize. This stage also contributed to the development of a more sensitive search strategy through familiarization with the research topic and terms used.
- Initial database searches were conducted as part of the protocol/scoping exercise, and website searches, hand searching and citation checking were completed by June 2016.
- A total of 11,679 references were generated from the searches:
  - 2 percent (n=242) of the studies were removed as duplicates
  - 92 percent of the remaining 11,437 references were excluded on title and abstract (n=10,551), mostly because they were not evaluating a mental health or psychosocial programme
  - the research team obtained and re-screened the full-text reports of all potential 886 citations remaining – they excluded 786 of these
  - four studies were ongoing and a further three studies were not written in English
  - a total of 82 distinct research studies were included in the review, with a further 18 kin studies, of which:
  - 13 evaluated the process of implementation or receipt of MHPSS programmes
  - 69 evaluated the impact of MHPSS programmes on children (n=40) or adults (n=29); the research team included 29 RCTs in the impact synthesis on CYP and 20 RCTs on adults.
- Although the evidence base of the 82 included studies spans a date range from 1998 (n=1) to 2015, the largest concentration of studies was published after 2010 (n=54), and even more recently between 2014 and 2015 (n=21).
- The majority of studies were conducted in man-made disaster settings (n=54), such as civil wars, including refugee settings with children and adults. Twenty-three studies were delivered in natural disaster settings. Evaluations were overwhelmingly conducted in post-disaster settings (n=63). Two studies evaluating MHPSS programmes responding to immediate crises were conducted in the context of natural disasters. Programmes delivered during humanitarian emergencies were in ongoing conflict settings (n=17), many of which were in the Middle East (e.g. Egypt, Syria, Palestine).

Figure 4: Overview of studies included



Further considerations

Future considerations might include:

- generating evidence on basic services and security programmes, cost-effectiveness, MHPSS programmes in ongoing conflict and natural disaster settings, and gender- and age-specific evaluations
- adopting consistent approaches to measuring mental health and psychosocial outcomes across settings – long-term follow-ups for impact and process evaluations could also be considered and incorporated into study design to inform the sustainability and maintenance of benefits, or to detect harmful consequences
- measuring other psychosocial outcomes such as resilience, coping and social support and other mental health presentations such as substance misuse or suicidal ideation.

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